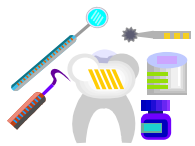

DRAFT

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH, WELLNESS AND DISEASE CONTROL
MICHIGAN DENTAL PROGRAM (MDP)

FY 07/08

Demographics

Name: _____
Last First Middle Initial

SS#: __ __ __ - __ __ - __ __ __ __

Date of Birth: __ __ /__ __ /__ __ __ __

Preferred Mailing Address (All MDP related mail will be sent to this address):

_____

_____

Are you a Michigan Resident? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

City: _____ State: _____ Zip Code:_____

County: _____ Phone Number: ( )_____

Gender (check one):	Race:	Ethnicity:
☐ Male ☐ Female ☐ Transgender	☐ African American ☐ Asian ☐ Caucasian (White) ☐ Pacific Islander/Native Hawaiian ☐ Native American	☐ Hispanic/Latino ☐ African National ☐ Arab/Chaldean

Are you enrolled in the Drug Assistance Program?
☐ Yes ☐ No If yes, list DAP Subscriber ID →

8-digit DAP Subscriber ID-found on RxAmerica card:
___ ___ ___ ___ ___ ___ ___ ___

Income/Other Coverage Eligibility

Family Size:_____ (including self, spouse &/or dependants living with you)

My TOTAL gross (pre-tax) **monthly** income is:
$_____(see application instructions for income verification requirements)

YES	No	
☐	☐	Do you have Medicare?
☐	☐	Do you have Private Health Insurance? (such as BC/BS, PHP, HAP)
☐	☐	Do you have Private Dental Insurance? (such as Delta Dental, BC/BS)

Dental Provider/Dentist Information (if available)

Date of last dental appointment: __ __ / __ __ / __ __ __ __

Dentist and/or Practice name: _____

Contact Person: _____

Phone : _____ Fax : _____

HIV Status/Lab Update (Please attach recent lab results if available)

Absolute CD4 number/mm3: _____	Test Date: _ _/_ _/_ _ _ _	Labs attached? ☐ Yes ☐ No ***(labs must show a detectable viral load and/or Positive/Reactive Western Blot)**
HIV RNA/ Viral Load: _____ copies	Test Date: _ _/_ _/_ _ _ _	**Physician Signature:** _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that if I become enrolled in a dental insurance program or I qualify for dental assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Michigan Dental Program and my dental provider, and that I also am not eligible for MDP assistance.

I authorize the Michigan Department of Community Health, Michigan Dental Program to receive, disclose, and discuss medical/dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program representative, or other individuals as required and necessary. In addition, specific agencies/representatives and phone numbers are listed below.

The information that I have provided on this application is complete and true to the best of my knowledge, and I certify that I meet the eligibility requirements as specified in the instructions that are required for me to be on the Michigan Dental Program.

I understand that if any of the information provided on this application changes that I will notify the MDP immediately. In addition, I understand that failure to report changes and/or reporting of inaccurate information will affect MDP coverage and program eligibility.

I understand that my enrollment in the MDP is completely voluntary and therefore agree to access care in accordance with MDP guidelines. I also understand that, as requested, I may need to submit additional information to continue enrollment up to and including annual renewal for the MDP.

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

AGENCY OR PERSON **PHONE NUMBER**

_____

Case Management (please list name and/or agency and phone number if you have one)

_____

Dentist

_____

Physician

_____

Other (family members, friends, partners)

_____ _____ **This consent expires 3/31/2008**

Signature of Applicant/Parent/Guardian **Date**

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:
Michigan Dental Program
109 Michigan Avenue, 9th Floor
Lansing, Michigan 48913
Phone: (888) 826-6565
Fax (517) 335-7723

MDP office use only	
Confirmed MDP Coverage:	
☐ Medicaid ☐ Michigan Resident ☐ Income ☐ Labs(Proof of Status) Approved _____ Date _ _/ _ _ / _ _ _ _ Initials_____	Denied _____ Date _ _/ _ _ /_ _ _ _ Reason Code: _____ Initials_____